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NOMINATION OF WILLIAM L. ROPER

HF177

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

ON THE

NOMINATION OF

WILLIAM L. ROPER TO BE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION

APRIL 22, 1986

Printed for the use of the Committee on Finance

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NOMINATION OF WILLIAM L. ROPER TO BE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION

APRIL 22, 1986

U.S. SENATE,
SENATE FINANCE COMMITTEE,
Washington, DC.

The committee met, pursuant to notice, at 8:30 a.m., in room SD-215, Dirksen Senate Office Building, the Honorable David Durenberger presiding.

Present: Senators Durenberger, Danforth, Symms, Baucus, and Bradley.

[The press release announcing the hearing, the prepared statement, and résumé of Dr. William L. Roper follow:]

[Press Release No. 86-033]

PRESS RELEASE

For immediate release, Thursday, April 17, 1986.
Contact: Anne Cantrel, (202) 224-4515.

FINANCE COMMITTEE TO REVIEW ROPER NOMINATION

Senator Bob Packwood (R-Oregon) announced today that the Senate Committee on Finance will hold a hearing on April 22 to review the nomination of William L. Roper to be Administrator of the Health Care Financing Administration.

Senator Packwood said that Senator Dave Durenberger (R-Minn.) will chair the Committee hearing which is scheduled to begin at 8:30 a.m., Tuesday, April 22, in Room SD-215 of the Dirksen Senate Office Building.

Dr. Roper, from Birmingham, Alabama, is Special Assistant to the President for Health Policy. Previously, he was a White House Fellow with responsibility for health policy issues. From 1977 through 1983, Dr. Roper was Director of the Jefferson County Department of Health in Birmingham. He also was Assistant State Health officer in Alabama and had taught health policy and public health administration at the University of Alabama in Birmingham.

Dr. Roper received his bachelors' degree, medical degree and masters of public health degree from the University of Alabama.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR-DESIGNATE, HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman, distinguished Senators: It is indeed a pleasure for me to appear before you today. I welcome the opportunity to respond to your questions and to discuss with you matters of health financing policy affecting our Nation.

I am grateful to President Reagan for his confidence in me, as evidenced by this nomination. It has been a high honor for me to serve on his staff as his Special Assistant for Health Policy, and, if you consent to my appointment, I look forward to serving in another capacity in his administration.

Secretary Otis Bowen has often been noted as the first physician Secretary of Health and Human Services. However, I believe that he will also be remembered as one of the most effective cabinet members we have ever had. His trust in me means

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a great deal, and I hope to have the challenge of helping him manage this important Department.

It is with a real sense of humility that I appear before you today as the President's nominee for this important post in our Government. The work that lies ahead of me will be long and hard. I know after spending time with many of you over the last several weeks, there are no easy answers to the difficult and vitally important health care financing questions facing the President and the Congress—I know better than ever, after talking with you, how diligently and how earnestly you, as well as the President, have worked to shape these important programs.

But I also must say that I feel a sense of excitement and anticipation to meet the challenges that are before me. There may be no easy answers, but I promise you I will devote all my energies to exploring the existing alternatives and to finding new ones.

I am looking forward to working with you and your colleagues. Should I merit approval by this committee and confirmation by the Senate, I promise that I shall faithfully and honestly discharge the duties of the office to the best of my ability.

A short-term goal of mine is to work with the Secretary toward his appointing a number of highly qualified and motivated people to fill the many vacancies that exist throughout the agency. My hat goes off to the staff, both career and political appointees, who have done double-duty over the last several months with so many open slots. They really have served tremendously—I note especially the outstanding job that Henry Desmarais in doing as Acting Administrator, under difficult circumstances—I hope we soon can bring them some assistance.

There is another issue I want to raise today: The importance of ensuring quality care in this era of prospectively set payments.

This administration is anxious to improve quality in the Medicare Program. We will do so because it is the right thing to do. As a physician, I do not seek the position of HCFA Administrator in order to preside over an erosion in the quality of its programs.

In closing let me say:

We are poised at the edge of a new era in health care and the shape of tomorrow is not always clear. A few things, however, do appear certain:

The health care of tomorrow is going to be even better than today's. One reason it will be better is that resources will be more tightly focused on getting quality results.

We are in the midst of major changes in health care, in America, as you well know. We are anxious to stimulate innovation in health care financing and delivery. The proper Federal role should be to set the general conditions for a fair and competitive marketplace, while protecting Medicare's beneficiaries.

I am excited about the opportunities, and I look forward to your comments and questions. Thank you very much.

Outline of Information Requested of Nominees

A. BIOGRAPHICAL

1. Name: William Lee Roper.
2. Address: 3805 North Vernon Street, Arlington, Virginia 22207.
3. Date and place of birth: July 6, 1948, Birmingham, Alabama.
4. Marital status: Married, Maryann Jedziniak Roper.
5. Names and ages of children: None.
6. Education: Florida College, 1966–68, A.A., 1968; University of Michigan, 1968; University of Alabama, 1969–70, B.S. 1970; University of Alabama, School of Medicine, 1970–74, M.D., 1974; University of Alabama in Birmingham, School of Public Health, 1978–81, M.P.H., 1981.
7. Employment record:

Resident in Pediatrics, University of Colorado Medical Center, Denver, Colorado, 1974–77.

Health Officer, Jefferson County Department of Health, Birmingham, Alabama, 1977–83; on leave 9–82 through 8–83.

White House Fellow, The White House, Washington, D.C., 9–82 through 8–83.

Special Assistant to the President for Health Policy, The White House, Washington, D.C., 12–83 until present.

8. Government experience:

Community Fellow, Department of Health and Hospitals, City and County of Denver, Colorado, 1975–76.

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Health Officer, Jefferson County Department of Health, Birmingham, Alabama, 1977-83; on leave 9-82 through 8-83.

Assistant State Health Officer, Alabama Department of Public Health, Birmingham, Alabama, 1981-83; on leave 9-82 through 8-83.

White House Fellow, The White House, Washington, D.C., 9-82 through 8-83.

Special Assistant to the President for Health Policy, The White House, Washington, D.C., 12-83 until present.

9. Memberships: Jefferson County Medical Society, Medical Association of the State of Alabama, Alabama Public Health Association, American Public Health Association.

10. Political affiliations and activities: In the spring of 1976, I served as a part-time volunteer in the Denver, Colorado, Carter for President, campaign, working in a telephone bank.

11. Honors and Awards:

Florida College: Phi Theta Kappa, Junior College honorary Who's Who Among Students in American Junior Colleges.

University of Alabama: Phi Beta Kappa, Outstanding Senior in Chemistry, Distinguished Undergraduate Scholar in the College of Arts and Sciences.

University of Alabama School of Medicine: State Merit Scholar, Alpha Omega Alpha.

Guy M. Tate Award of the Alabama Public Health Association.

12. Published writings:

Roper W.L.: "Pasteur and Rabies." *Alabama Journal of Medical Sciences*, 11:56-62, 1974.

Altenburger, K.A., Jedziniak, M.T., Roper, W.L., and Hernandez, J.: "Complete Congenital Heart Block and Hydrops Fetalis." *Journal of Pediatrics*, 91:618-620, 1977.

Holmes, J.R., Plunkett, T., Pate, P., Roper, W.L., and Alexander, W.J.,: "Emetic Food Poisoning Due to Bacillus Cereus." *Archives of Internal Medicine*, 141:766-767, 1981.

Roper, W.L., Bridgers, W.F.: "Organizations and Activities of Local Public Health Departments in Alabama." *Alabama Journal of Medical Sciences*, 20:208-216, 1983.

Alexander, W.J., Holmes, J.R., Shaw, J.F.E., Riley, W.E., and Roper, W.L.: "Norwalk Virus Outbreak at a College Campus," *Southern Medical Journal*, 79:33-36, 1986.

Senator DURENBERGER. Today's hearing is on the nomination of William L. Roper to be the Administrator of the Health Care Financing Administration.

Bill, why don't you come on up and bring your Senator with you and take a seat at the hearing table. We welcome you. I will probably have a couple of things to say after Howell does.

We are personally privileged to have Howell Heflin here today and, Howell, let me give you the opportunity to say whatever you would like to say on behalf of Dr. Roper.

STATEMENT OF SENATOR HOWELL HEFLIN

Senator HEFLIN. Mr. Chairman and members of the committee, it is a pleasure for me to appear before the committee to introduce Dr. William Roper who has been nominated to serve as the Administrator of the Health Care Financing Administration of the Department of Health and Human Services.

Dr. Roper, a Birmingham, AL, native, received his associate of arts degree, AA, from Florida College and then graduated from the University of Alabama with a BS degree where he was named Phi Beta Kappa and he was the Distinguished Undergraduate Scholar of the College of Arts and Science for 1970. He received his M.D. degree from the University of Alabama in Birmingham. While in medical school he was named to Alpha Omega Alpha, the honor medical society, and he served as class president each year during his 4-year stay in medical school.

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In 1974 Dr. Roper went to the University of Colorado Medical Center for his internship and residency in pediatrics. He is board-certified in the medical specialties of pediatrics and preventive medicine.

Dr. Roper has also engaged in specialized studies involving public health and pediatrics in Washington, DC, and Edinburg, Scotland. In 1981 Dr. Roper returned to his native Birmingham to receive his masters in public health degree from the University of Alabama at Birmingham School of Public Health.

Dr. Roper has not only excelled academically, he has also maintained an outstanding record throughout his professional career. He has served on numerous professional and community boards, and is author of several articles.

Dr. Roper served as the health officer of Jefferson County, AL, Department of Health in Birmingham, which is the largest county in the State of Alabama, for a period of 6 years. He also taught health policy and public health administration, at the University of Alabama, at Birmingham's School of Public Health. He has been the assistant State health officer in Alabama, and was the legislative liaison for the Alabama Department of Public Health.

In 1982 Dr. Roper was selected as a White House fellow where he helped fashion the administration's policy for health issues. He currently serves as a Special Assistant to the President for Health Policy, with responsibility for health affairs.

Mr. Chairman, I sincerely believe that Dr. Roper's extensive experience in the field of health care, coupled with his sound reputation and impeccable character, will make him an outstanding Administrator of the Health Care Financing Administration of the Department of Health and Human Services. I know that Dr. Roper possesses the qualifications to discharge the responsibilities and the duties of his position in an excellent manner.

We are particularly delighted to have him from Alabama since now I can refer all the doctors who complain of the DRG's and admission problems and everything else. They will know him personally and so they won't have to use my office as a conduit to get to the bureaucracy. [Laughter.]

So we are delighted that he is here and I am delighted to introduce him and commend him to this committee.

Senator DURENBERGER. I will tell you, that is a noble goal, and if you think he is going to be able to handle all of the problems of all of those Alabamans, I think you may have another think coming.

Judge Heflin, we all respect your judgment around here and we have come to learn to do that because of the fact that you are very careful about the way in which you bestow the blessings of your personal judgment on people, and, frankly, I am not only grateful to you for getting up early this morning, but I am impressed by the fact that you would be here on behalf of the nominee because it means something special.

For those of you who don't know Senator Judge Heflin as well as some of the rest of us, it really is an important part of this nominating process to have the senior Senator from your State here to say the nice things about you that he did, and I am sure it had nothing to do with the last paragraph of that speech, where he is

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going to refer all of the business to you, because that certainly is impossible. I already have a line of Minnesotans——[Laughter.]

Senator DURENBERGER [continuing]. Waiting outside the door at HCFA and I think there are 19 other States represented on this committee and they are in line before Alabama. So I guess that means, if I add that up right, there are about 79 States that are in trouble, and one Administrator, who has a full-time job——

Senator HEFLIN. No; you have that wrong. One Alabaman is equal to two or three. [Laughter.]

Senator DURENBERGER. Howell, thank you very much for coming.

Senator HEFLIN. Thank you.

Senator DURENBERGER. Bill, I am going to ask you in just a minute to say whatever you would like to say as part of this hearing and you can take probably as much time as you want to do it. We obviously scheduled this meeting early this morning because we thought we were going to be having markup. The Finance Committee is starting at 9:30. Instead we do have a hearing here at 9:30 on a rather controversial international issue and we tried to leave as much time as possible, plus sort of fall-back time, in case there were a variety of other questions of you from members of the subcommittee.

Before I introduce you for purposes of making your own statement, let me introduce to everyone here Mr. Richard Roper, your father, who is here. Mr. Roper, thank, you for being here. And his friend, Mr. Harold Middleton; and your wife, Maryann, who is a pediatrician, is here; and her parents, Ed and Helen Jedzxiniak, who are now my new Polish friends. We appreciate very much your being here for this very significant occasion in the health policy history of this country.

I have known Bill Roper for a relatively brief period of time, but, while the association may be brief, it is also impressive. This administration, unlike some of its predecessors, has not necessarily featured the domestic policies side of the White House. Instead, our focus over the first 5 plus years of the administration has been largely on budgetary issues, and budgetary issues have made $2.4 million for one former member of the administration. Budgetary issues have caused some people to sort of come and go in the policies side of this administration.

Bill Roper is a person who came, without the intention of staying, I am sure. I won't try to say that for you, but that is my recollection. He came first as a fellow, one of these people that comes for an experience, and then, after the thrill has worn off, leaves. I suspect the thrill has not worn off for Bill Roper because of the fact that the administration and the Congress in the area of health are engaged not in budgetary reform, but in health policy reform, and because there are not a lot of people at the White House doing domestic policy reform, the burden for behind-the-scenes policy leadership gets to be shared between the Department of HHS and the domestic policy staff, and on the domestic policy staff side has been almost in total Bill Roper.

So, if there is a person who is well prepared in a sense of policy direction this country is going to take over for a person who was a very unique, not only by reason of her longevity, but by reason of her commitment, Administrator of the Health Care Financing Ad-

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ministration, it is Bill Roper. Bill's contribution through the working group on health policy and a variety of other contributions that he has made are well known to the handful of us who labor in this field of health policy reform, and I certainly expect, Bill, that if you can overcome some of the other problems that face you at HCFA in terms of the budgetary pressures and so forth, that together we are going to be able to get some more policy reform accomplished over the next 3 years or however long your tenure may be.

I would like to note for the record that the committee has reviewed Dr. Roper's financial disclosure materials. A letter from the Director of the Office of Government Ethics signifying Dr. Roper's compliance with the Ethics in Government Act will be made part of today's hearing record.

[The letter from the Office of Government Ethics follows:]

United States of America
Office of Government Ethics

Office of Personnel Management
P.O. Box 14108
Washington, D.C. 20044

MAR 25 [illegible]

Honorable Robert Packwood
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by William L. Roper, who has been nominated by President Reagan for the position of Administrator of the Health Care Financing Administration (HCFA), Department of Health and Human Services.

We have reviewed the report and have also obtained advice from the Department of Health and Human Services concerning any possible conflict in light of the Department's functions and the nominee's proposed duties. Mr. Roper has indicated on his report that he is on leave of absence from the School of Public Health at the University of Alabama at Birmingham. The designated agency ethics official has indicated his intent to recommend to the Secretary that, upon Mr. Roper's confirmation, the Secretary issue a waiver under 18 U.S.C. 208(b)(1) so that Mr. Roper might participate in official actions that may affect the University of Alabama to the same extent they affect other universities. The waiver would not extend to matters specifically involving that University.

Based on the issuance of this waiver, we believe Mr. Roper is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

David H. Martin
Director

Enclosure

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Senator DURENBERGER. Steve, do you have any comments you would like to make? What I intend to do is introduce Bill to make a brief statement and then respond to questions.

Senator SYMMS. That would be fine. I am glad to be here this morning to hear Bill's statement; Dr. Roper, I guess we should say.

Senator DURENBERGER. I guess we should.

Senator SYMMS. And then I will have a few questions I would like to ask.

Senator DURENBERGER. Until he shows up on a Carolyne Davis tee-shirt, or something like that, we will have to call him Doctor. [Laughter.]

Dr. Roper, I welcome you to this hearing and also to the opportunity with which you have been presented.

STATEMENT OF DR. WILLIAM L. ROPER

Dr. ROPER. Thank you, sir.

Mr. Chairman, distinguished Senators, it is a pleasure for me to appear before you today. I welcome the opportunity to respond to your comments and questions and to discuss with you matters of national health financing policy. I do want to talk about policy.

I am grateful to the President for his confidence in me as evidenced by this nomination. It has been a high honor for me to serve as a member of his White House staff, as his Special Assistant for Health Policy. I look forward, if you consent to my nomination, to serving him in another capacity in his administration.

Secretary Otis Bowen has often been noted as the first physician Secretary of Health and Human Services, but I think he is also going to be remembered as one of the most effective Cabinet members we have ever had. His trust in me means a great deal and I hope to have the challenge of helping him manage this important Department.

It is with a real sense of humility that I appear before you today as the President's nominee. The work ahead is going to be long and hard. I know, after talking with you and other Members, that there are no easy answers to the difficult and important issues that face you and the President. I know better than ever, after hearing from you, how much you have worked diligently and earnestly to shape these important programs, Medicare and Medicaid, but I also have a great deal of excitement and anticipation to meet the challenges that lie ahead. There are no easy answers, but I promise I will be working to explore all the alternatives and to find new alternatives.

I look forward to working with you Senators and your colleagues, and I promise that I shall faithfully and honestly discharge the duties of the office to the best of my ability.

A short-term goal of mine is to work with the Secretary toward his appointing a number of highly qualified and motivated individuals to fill the many vacancies that exist throughout HCFA. I want to take a moment and salute the hard-working staff, both career and political appointees, who have done double duty over the past months with so many of the slots vacant. Especially, I would like to thank Henry Desmarais for the outstanding job that he is doing as Acting Administrator under difficult circumstances. I hope soon that we can bring them some assistance.

There is another issue that I would like to raise today and that is the importance of insuring quality care in this era of prospectively

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set payments. This administration is anxious to improve quality in the Medicare Program. We will do so because it is the right thing to do.

As a physician, I do not seek the position of HCFA Administrator in order to preside over an erosion in the quality of its programs.

Finally, let me say we are poised at the edge of a new era in health care and the shape of tomorrow is not always clear, but a couple of things do appear certain to me.

First, the health care of tomorrow is going to be even better than today. One reason that is going to be the case is that resources will be more tightly focused on getting quality results.

And, second, we are in the midst of major changes in health care in America, as you well know. We are anxious to stimulate innovation in health care financing and delivery. It seems to me the proper Federal role should be to set the general conditions for a fair and competitive marketplace while protecting Medicare's beneficiaries.

I am excited about the opportunities that lie ahead and I look forward to your comments and questions.

Thank you very much. I would like to say thank you to my Senator, Senator Heflin, for his kind introduction.

Senator DURENBERGER. And thank you for reminding me of something that I should have said in my opening statement, and that is complimenting Henry Desmarais for the——

Dr. ROPER. He is here.

Senator DURENBURGER. Yes, I know. Because at various times we have been at apparent odds over the years on some issues only because the administration is going that way and we are going this way, and we are both going in the same direction but slightly different tracks. I just think, as an observation, working so closely with HCFA, listening to people talk about what Henry has had to do in this interim period, that I just want to publicly commend him on his leadership in a difficult situation, and also the other people. It isn't just Henry, but there are a lot of other people on that staff over there who, in this so-called period of uncertainty, out in the offices, out around the country, the same kind of situation exists. There is a lot of good leadership in your organization that cannot be recognized by name, but when they are sort of put to the test in one of these who's-the-leader-today kind of situation, they really have come through very well, and I would like to compliment them indirectly, all of them, but particularly I want to compliment Henry for the work that he has done.

Steve, do you have questions or comments?

Senator SYMMS. Thank you very much, Mr. Chairman, and Doctor, thank you, and I wish you good luck in the challenge that lies before you.

I just want to bring up a couple of points that are of a keen interest on my part, particularly this health care financing question which requires that all Medicare intermediaries deny claims or recover dollars on a 5-to-1 ratio, meaning that for every dollar spent by the Government in audit and review, that they have to recover $5. Because of the fact that Blue Cross was not able to meet that mandate, in Idaho they have lost out on being the Medicare intermediary, and this comes after a 20-year history in Idaho of Medi-

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care Part A administration by Blue Cross which has now forced the contract to be opened up for other people to bid on.

But I just want to make a point here and ask you the question that I am concerned about. It is all well and good to have these targets and goals on a national average. It just happens, however, that Idaho is the one State in the Union that sets the standard for the rest of the Nation. If the rest of the Nation would do as well as we do in Idaho on the job of dispersing medical health delivery, it would save $11 billion in Medicare payments, $11 billion, which would go a long way toward meeting the targets of Gramm-Rudman.

Now, we are 29 percent below the national average. Boise has the lowest per-patient Medicare cost in the Nation. As I said, it would save $11 billion if the rest of the Nation would do as well as Idaho. Yet what we got is kicked in the head for having done a good job because they couldn't come up with a 5-to-1 savings.

Now, as a physician, do you believe it is possible for a State with the lowest Medicare costs in the Nation to have to deny enough claims, whether they are good or bad, to meet this mandate? And are you in the administration of HCFA going to allow medical quality to deteriorate in order to meet some arbitrary mandate set by the bureaucrats in Washington?

Dr. ROPER. Thank you, Senator, I appreciate that question. [Laughter.]

As I said in my statement, I certainly do not want to do anything to degrade the quality of the Medicare Program. In fact, I would like us to spend the next 3 years enhancing the quality of the program, so that we are not arguing over whether things have fallen, but how much they have risen.

Now, concerning the particular points you raise about the intermediary in Idaho: You and I spoke about this yesterday in your office. That was the first time it had been called to my attention, and I said to you then and will say again to you today, I will certainly look into the situation there and see what the facts are. It is clear that, from my general knowledge, that Idaho uses health care services at a very low rate and we would like to see if some of the good things that you are doing in Idaho can be put in place in other parts of the country. The good things that you are doing surely should not be reason for punishing you.

Senator SYMMS. Well, that brings me to my next question.

I have discussed this issue with Secretary Bowen's office and they suggested that we submit a proposal to establish Idaho as a demonstration project which would incorporate these practices. I want to know if you would be willing, as the new Administrator of HCFA, to—and I guess you have almost answered that already—to give that proposal careful attention, because it appears to me that what we should do is keep on doing what we are doing in Idaho and then use that as a demonstration project for the rest of the United States, and we have a built-in way to come up with, say, $10 to $11 billion in savings.

Dr. ROPER. Yes, sir; I would sure like to take a look at it.

Senator SYMMS. I know that the—well, thank you. We will work with you on that.

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I think you know that we are really concerned about this and I just think, Mr. Chairman, that this is an issue that oftentimes happens when you have a national program like this, that, when you try to talk about averages and so forth, we end up having difficulties.

And another question I want to just ask you about, or at least bring to your attention, they have this classification of rural versus urban. We have a problem in north Idaho with Coeur d'Alene Hospital that they have to compete against the Spokane hospitals, and it is only a 30-minute drive down the interstate to Spokane; yet in Spokane you get paid a higher payment on a DRG than you do in Coeur d'Alene. Same thing is true in Caldwell Nampa versus Boise.

I don't know what the answer to that is, but it seems to me like this is an extremely unfair possibility, and the sooner you could go to some kind of a national average or something, the better off we would be.

Do you have any comments you would want to make or any ideas of about how to solve that problem?

Dr. ROPER. Well, a couple of weeks ago Senator Baucus taught me a lot about rural hospitals. I was beginning to tell him that I am from a rural State, Alabama, but he explained to me that the rural West is different from rural areas in the Southeast part of the country.

Seriously, though, you raise a problem that Medicare faces, and that is this disparity in payments, not only for hospitals but doctors and other providers of health care services. We pay less in rural areas than we do in urban areas.

Now, the difference in payment for hospitals came about by, I am sure, well-intentioned Members of Congress who wanted to add that change onto the proposal for prospective payment back in 1983. It just makes sense to me that we do what you say, and that is even out, at least more nearly even out, the payments between rural and urban areas. If we have fewer services now in rural areas and we want to get doctors to locate in those areas, the simple, straightforward market-oriented way to do that is to pay people more and they will locate to do business in those areas.

So, in a general way, I want to be addressing the problem of rural health care. As I told Senator Baucus, I do not have any magic answers, but I pledge to you and to him and to others that I will be spending a lot of time on that issue.

Senator SYMMS. Well, one other thing that I wanted to mention is that there—is there some plan that you are aware of or do you have intentions to some way try to regionalize the intermediaries? I mean, is that a hidden agenda that HHS and HCFA have?

If that is the case, I would urge you to put it out public, because we have had a lot of good people in Idaho who I think have done an excellent job that are getting some kind of a bum rap, and the appearance comes out that somehow they haven't been doing their job.

Dr. ROPER. If I am understanding your question——

Senator SYMMS. Do you understand what I am saying?

Dr. ROPER. Yes; you want to know what the true plan is, and I pledge to you that we will be truthful with you and forthright and not——

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Senator SYMMS. And one other point that has always been a bone of contention to me, and I don't have to put this in the way of a question but basically just a statement: I think it is just outrageous that, if a physician has, say, an office call charge of $20 for a patient to come and make a call at his office or her office, and then the Government writes a check to the—or a letter to the recipient of Medicare and says, so to speak, "Well, we only pay $11.88 for this office call and your doctor has overcharged you."

I would hope that someone would change the language in those letters at least to say that "Your doctor cannot operate his office or her office for the charge of $11.88; therefore, there will be an additional charge, but we are going to pay $11.88," or whatever the amount is.

But, to me, all of this interference in the way some of these things have been handled with the insensitive text of the letters, it makes it look like, you know, "Dear Mrs. Brown, Your doctor just ripped you off for $8, so we'll only pay $12." And this is causing a big wedge between physicians and their patients, which is the worst possible prescription for good medical delivery system in the United States. We should allow a very good, close patient-doctor relationship to exist so we don't see an impersonal, insensitive delivery of medicine.

I would hope that you and Dr. Bowen, as physicians, would, in the carrying out of your duties, really attend part of your time and responsibility to do what you can from the Federal level to make these programs operate in a sensitive fashion so we don't drive this wedge between doctors and patients any more than has already been done. I see it happening, when you see polls where physicians are not as popular as they used to be and so forth, and the only thing this bodes for the future will be poorer medical care for the American people, which I think is something none of us want.

I wish you good cheer and I am going to submit a few more questions in writing, if it is all right, Mr. Chairman. Thank you very much.

Dr. ROPER. Thank you, sir.

Senator SYMMS. Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you very much, Steve. Max.

Senator BAUCUS. Thank you, Mr. Chairman.

Dr. Roper, following up on some of the points made by Senator Symms, I wonder if you could tell us a bit more precisely how you intend to address rural health care concerns. I understand the general principle.

Dr. ROPER. Yes, sir.

Senator BAUCUS. But I am looking for something a little more precise.

Dr. ROPER. Well, I don't have more precision at this point, Senator. I believe the problem is multifaceted. It arises, in some respects, because we pay less in rural areas. That is why doctors cannot locate there. Rural hospitals face some particular problems, the small ones particularly in the West, as I mentioned earlier.

The current law has some provisions: the sole community provider provision, the swing bed provision that you were instrumental in putting in place, and so on, but I don't think these provide all the answers. But I have, as I said, pledged to work on this matter because I am not confident we have solved it.

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Senator BAUCUS. How strongly are you going to push a fixed-price capitated payment system for health care? I know that you have been an advocate of that in the White House.

Dr. ROPER. Yes, sir.

Senator BAUCUS. I am sure you also know that HMO's and private insurers have troubles with that in sparsely populated areas, particularly. How strongly are you going to push that?

Dr. ROPER. Well, I am going to push it strongly, with the understanding that it is a policy initiative that has some unanswered questions. You just raised an important one: How applicable are capitated systems to rural areas? I don't want to be bull-headed about it and run roughshod over people who have concerns. As I have said repeatedly around the country, I believe in capitation, but I want it to be successful for beneficiaries and for providers, for doctors and hospitals and others. And I think it is important that we answer those questions before we proceed.

Senator BAUCUS. Again, that is a general principle. You have given some thought to this, obviously.

What are some of the preliminary thoughts you have had as to how to address capitated payment systems in rural areas? You have obviously thought about it, so what are some of your preliminary thoughts?

Dr. ROPER. I think a preliminary thought would be, the kind of capitated system that works in an urban area may not work in a rural area. For example, when one says "capitation," many people immediately think HMO, health maintenance organizations, but capitation simply is paying a fixed amount to somebody who manages health care. I think capitated systems that pay doctors and hospitals on a fee-for-service basis, rather like they are paid now, are probably the kind that would have to be in place in a rural area. I don't know whether a traditional HMO would work in a rural area.

Senator BAUCUS. There aren't any so far.

Dr. ROPER. Pardon?

Senator BAUCUS. I am just saying, in my own State of Montana, there are not any; there aren't enough people.

Dr. ROPER. But the fact that a traditional closed panel HMO may not work in a rural area does not mean that capitation cannot work in a rural area.

Senator BAUCUS. I just strongly advise you to proceed very cautiously, because, unless you have lived in a very, very sparsely populated area, it is hard to understand how different it is living there and how different health delivery systems are in rural areas compared with other areas of the country. It is just absolutely critical.

Dr. ROPER. Yes, sir.

Senator BAUCUS. What are you doing at HCFA to address the problem of increasing Medicare deductibles? As you well know, over a 2-year period there will be a 43-percent increase in the Medicare part A deductible, a rise from $400 to $572. That is a 43-percent increase, which far outstrips inflation that senior citizens have to face or increases in their income. What is HCFA going to do about that? What is the administration going to do about that?

Dr. ROPER. The administration is going to study it. Secretary Bowen has asked for an intensive, immediate study as a reaction to

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some of the projections of how the deductible is likely to rise in the future.

As you know, the deductible is calculated on a formula, an average cost per day. As the number of days has fallen, the average cost has risen. What I think you are saying, and what we are saying, is "Does that formula still make good sense?"

Senator BAUCUS. Well, I don't think senior citizens care much about formulas.

Dr. ROPER. Well, the formula is in the law.

Senator BAUCUS. What they care about is paying more the CPI, more than inflation.

Dr. ROPER. Right.

Senator BAUCUS. Why hasn't the administration automatically corrected that?

Dr. ROPER. The formula is written in the statute, sir.

Senator BAUCUS. Why hasn't the administration automatically come up with a proposal to correct it?

Dr. ROPER. We are in the process of studying it.

Senator BAUCUS. Why hasn't the administration done it thus far? Is it cost? Did OMB say it costs too much?

Dr. ROPER. Well, I think deductibles and copayments are an appropriate part of managing a health care system. The question that you are raising, and that many of us are now asking, is "Has the deductible risen to the point that it is an inordinate barrier to entry, particularly to the low-income elderly?"

Senator BAUCUS. Do you personally think that it is fair for the deductible to increase 43 percent over 2 years? Personally, your personal view.

Dr. ROPER. I think it has risen fast, surprisingly fast.

Senator BAUCUS. That is not the question I am asking. I pointed out how fast it has been rising. We are not addressing whether it has been rising fast or not. We know that. That is established. That is a given.

The question is, is it appropriately rising that fast or is it unfair that it is rising that fast? Your personal view.

Dr. ROPER. I think it is unfair to many senior citizens, yes, sir.

Senator BAUCUS. You think it is unfair?

Dr. ROPER. I said it is unfair to many senior citizens that it has risen that fast.

Senator BAUCUS. OK. How far are we coming along in working out cooperation of the Congress and the capital passthrough in folding that into a PPS system?

Dr. ROPER. How far have we come?

Senator BAUCUS. Yes.

Dr. ROPER. The administration has put forward a proposal and the Congress has let us know in a very vigorous fashion that there are many concerns about that proposal. We had a meeting about a week ago that was very constructive. Your staff and other Members' staff were present. We invited them to come back with some specific alternative recommendations and we, either next week or thereafter, are going to have another meeting. I think last week's meeting showed a constructive desire to work together.

Senator BAUCUS. Don't you think it is also a bit unfair to spring these new regulations on the country with such short effective date

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when the administration had—I have forgotten the exact time, but a long time, lead time, in which to give the Congress and providers notice of the administration's intention?

Dr. ROPER. No, sir, I don't.

Senator BAUCUS. Why is that?

Dr. ROPER. Because the general outlines of the administration proposal have been generally known for months.

Senator BAUCUS. But not the specifics.

Dr. ROPER. Well, generally known.

Senator BAUCUS. On that same score—that is, cooperation—some time ago I asked for a HCFA report on an amendment I offered years ago on Medigap insurance. It has now been, I think, a few years since the administration has come forth with that. It is now several years overdue.

Why is that several years overdue?

Dr. ROPER. I am not aware of that specific report and what has held it up. As you know, we have been overdue on a lot of reports, and Secretary Bowen and his staff are working overtime right now to clear out that backlog. I think they already have made major progress.

Senator BAUCUS. I urge you to continue to make progress.

Dr. ROPER. Thank you, sir.

Senator BAUCUS. Thank you. Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you, Max.

Senator Bradley.

Senator BRADLEY. Thank you very much, Mr. Chairman.

Mr. Roper, good to see you.

Dr. ROPER. Good morning.

Senator BRADLEY. I wonder if you are familiar with the recent steps that HCFA has taken that have had the effect of reducing Medicare home health coverage.

Dr. ROGER. Senator, I am not aware of specific things. In the last couple of days, I have heard from a number of people, questions about the way we are managing the home health benefit, but I don't know specific steps.

Senator BRADLEY. Well, let me share with you a real concern that I have that was confirmed just yesterday when I held the hearing of the Aging Committee in my home state of New Jersey.

The fact is that since we have put in the DRG's, hospital stays have been reduced by about 2 days on average, which is positive; but more people are coming out of the hospitals without adequate home care coverage, which presents very serious health problems. We have this almost perverse interpretation of the regulations in New Jersey at least, where HCFA's denial for eligible home health care covered by Medicare has increased and there has been an actual decline in the admissions to home care. It seems to me that that creates the makings for a very real health crisis. The Government, on the one hand, tries to get people out of the hospitals sooner, in some cases "quicker-and-sicker," then on the other hand, we squeeze down on the available post-acute care home care benefits.

My hope is that you will take a look at the justification that has been offered for squeezing down on the home-bound criteria. Are you familiar with that?

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Dr. ROGER. Yes, sir; I am.

Senator BRADLEY. Do you have any opinion?

Dr. ROPER. Just some general ones, sir. Before I came to Washington, I ran a county health department in Alabama.

Senator BRADLEY. I know; that is why I am asking you.

Dr. ROPER. And I ran the largest home care agency in the State of Alabama. So I think I know a little bit about home care and the value of home care and the intensity that individuals and families feel about how desirable home care is.

As I said in my earlier statement, I don't know the specifics of what has been done in the last few days. I would just make one other point; That home care, despite the concerns that have been voiced, continues to be a very rapidly growing part of the Medicare Program. More money continues to go into that part of the program.

If we cut back on the length of stay in hospitals and people are discharged earlier, many of them are going to need services in the home, and so I understand, your general sentiment.

It is my understanding, finally, that the controversy is not so much over home care for people who have just been discharged from the hospital, but over individuals who have not been in the hospital at all, but who decide—or their doctor decides—need home care services. I believe we are discussing that latter group of patients, not the ones who have just emerged from hospitals.

Senator BRADLEY. Well, let me share with you another concern, in addtion to the home bound criteria. This concern of the provision of home care only for intermittent care.

Dr. ROPER. Right.

Senator BRADLEY. You find some people who need home care for, say, 4 days a week, but HCFA has interpreted anyone who needs it more than 3 days does not qualify for any Medicare coverage of home care. So you find people who need 2 or 3 days of care and they are covered under Medicare. But if they have another complication or whatever, and the doctor says they need another day of care, as soon as they go above that third day, they lose all medicare coverage.

Dr. ROPER. Yes.

Senator BRADLEY. That seems to me to be defeating the purpose here. Doesn't it to you?

Dr. ROPER. It is——

Senator DURENBERGER. Bill, before you respond, let me say to everyone that we have 4 minutes and 40 seconds left in this room, so please keep your response brief, and I will say that Senator Bentsen will have questions for the the record, as may Senator Danforth and others.

Senator BRADLEY. You can answer that for the record, if you would like.

[Dr. Roper's answers to questions from the committee follow:]

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

May 5, 1986

The Honorable Bob Packwood
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Please find enclosed the responses to the questions you raised for the record of the hearing on the nomination of William Roper, M.D. as Health Care Financing Administrator. This completes all questions submitted to Dr. Roper.

If you have any questions, please do not hesitate to call on me.

Sincerely,

Lawrence J. DeNardis
Acting Assistant Secretary
for Legislation

Enclosures

cc: Ed Danielson

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Senator Packwood Question 1

QUESTION: A recent study conducted by Harvard University concluded that the Medicare program urgently needs comprehensive reform. The Harvard proposals include recommendations that Parts A and B be combined into a single, mandatory program; that beneficiary cost-sharing be reduced; and that long term care benefits be increased. These changes would be financed through savings from program reforms and increased tax revenues. What do you think of the Harvard proposals?

ANSWER: The President has directed Secretary Bowen to report by year-end with recommendations on how the private sector and the government can work together to address the problem of catastrophic health care costs. In the course of this study, the Secretary plans to consider various proposals for reform and consult widely with Federal officials, members of the Congress, medical and consumer groups, and other representatives of the private sector.

The Harvard proposals are very pertinent to the catastrophic study and will be considered, along with other proposals, before developing a final report to the President. Likewise, the Harvard proposals on Medicare reform offer some thoughtful policy options for strengthening the viability of the program. Although I have not yet examined the Harvard proposals in detail, they appear to call for more government involvement in our health care system, rather than less, as is the long-term goal of this Administration.

Senator Packwood Question 2

QUESTION: The Department of Justice recently made recommendations for liability tort reform. These recommendations include such changes as a cap on awards for pain and suffering. Do these recommendations address medical malpractice? If so, how will these recommendations impact the study of medical malpractice reform that you are undertaking at the President's request?

ANSWER: The recommendations to which you refer were developed by the Domestic Policy Council's Tort Policy Working Group, which is chaired by an Assistant Attorney General. The Working Group recommended a number of changes in tort law that would affect tort actions of all types, including medical malpractice.

The Working Group did not specify whether its recommendations should be adopted at the State or federal level. Where there is sufficient federal interest to warrant federal legislation applying the principles to an area of tort law, the Administration intends to propose such legislation. I chair a task force of the Working Group on medical malpractice liability, and this task force is considering the proper role of the federal government with respect to implementation of these reforms in the area of medical malpractice liability.

Secretary Bowen's study of medical malpractice reform, directed by the President, is being conducted by HHS, in close coordination with development of policy on medical malpractice liability by the Tort Policy Working Group and its task force. A major focus of the HHS study is the appropriate role of the federal government in implementing the Working Group's recommendations. In addition, the HHS study may extend beyond the issue of tort reform.

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Senator Packwood Question 3

QUESTION: New Peer Review Organization (PRO) contracts will begin July 1, 1986. Although these contracts include many new features designed to strengthen review of quality of patient care, there may be additional changes that would be in our best interest to implement during the next two years. What process would be required to modify these PRO contracts, either to add new tasks or substitute for negotiated tasks?

ANSWER: The Scope of Work for PROs can be modified in two ways. First, there are changes in policy that modify the PRO's work that are consistent with the Scope of Work and do not change the "level of effort." These modifications are accomplished through the use of the PRO manual. Second, there are changes that are more significant and do affect the level of effort. These are handled in the same manner as modifications in other government fixed-price contracts. Revisions of work to be performed are submitted to the contractor for a "business and cost proposal" and new tasks are negotiated.

Senator Packwood Question 4

QUESTION: A number of hospitals in Florida and other states, have begun the practice of waiving deductibles and coinsurance as a means of maintaining their share of the Medicare market. Do you believe that hospitals should be allowed to waive beneficiary cost sharing? If so, should such waivers be permitted, on a case by case basis, for certain classes of beneficiaries, such as Veterans; or should the waiver apply to all Medicare patients admitted by a hospital?

ANSWER: As I understand it, the present situation is that the Office of the Inspector General of HHS considers routine waiver of deductible and coinsurance (that is waiver for all patients) by a hospital, potentially to be a criminal violation of the bribes, kickbacks and rebates provision of section 1877(b) of the Social Security Act; however, waiver of Part A deductible and coinsurance does not otherwise violate Medicare statutory requirements.

There are arguments on both sides of the issue of the desirability of permitting waiver of deductible and coinsurance by hospitals. On the one hand, collection of deductible and coinsurance helps to discourage overutilization of hospital services. On the other hand, waiver of Part A deductible and coinsurance is one way in which efficient hospitals can provide benefits to patients as a consequence of their greater efficiency.

Certainly, hospitals should be permitted to waive some or all of the deductible and coinsurance in cases where collection would cause serious hardship to the patient. However, hospitals should not be able to claim Medicare payment for deductible and coinsurance amounts which have been routinely waived for all patients.

Because of the complexities involved, I believe that this issue merits further examination before any specific action is taken to change current requirements with respect to hospitals' waiver of deductible or coinsurance amounts.

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Senator Packwood Question 5

QUESTION: Some researchers have argued there is limited indirect evidence that geographic variations in fees in Medicare's "CPR" system encourages physicians to locate in high fee areas thereby reducing the availability of physician services in low fee areas. Others argue that there is no rigorous or direct evidence which demonstrates that Medicare's physician payment system causes maldistribution of physicians across the U.S.

What research has HCFA conducted in this area? What other data and research are available? To what extent do you believe that Medicare's reimbursement policy runs counter to federal policy to provide physician services in medically underserved areas?

ANSWER: I agree that there is no rigorous or direct evidence demonstrating that the Medicare CPR system causes maldistribution of physicians across the U.S. Indeed, most of the evidence about the relationship between fees and physician location is inconclusive. The Report of the Graduate Medical Education National Advisory Committee suggests that statistical studies typically show a weak or negative association between the population of physicians in a State and average net physician income.

A review of the relevant literature by the Institute of Medicine suggests that noneconomic factors such as a physician's prior attachment to the location, the proximity of professional colleagues and health facilities, and social and cultural characteristics of the community, also have an important effect on physicians' location decisions.

HCFA studies to date have focused on issues of physician supply of services to various populations; physician-induced demand; and the influence of fees on physician participation decisions. I am not aware of any study that concludes that Medicare's payment system has caused a geographic maldistribution of physicians. The research conducted by other agencies in the Department have tended to study location in terms of broad manpower issues, such as overall supply and distribution of health professionals. For example, the Public Health Service supports and conducts extensive research on manpower distribution and reports findings periodically to the President and Congress in the Status of Health Personnel in the United States. One of the findings of the May 1984 report was that physician-to-population ratios in the United States have increased substantially over the last three decades, and that physician location choices tend to follow the general population trends. Also, increasing numbers of physicians are locating in counties having lower physician-to-population ratios.

Two studies by researchers at the Rand Corp. have examined physician location in rural areas. According to one study, as the supply of physicians grew during the 1970s, medical and surgical specialists diffused into smaller communities, and in 1979, nearly every town with a population of more than 2,500 had ready access to a physician. The article cites data which strongly suggest a major role played by competitive forces in determining where physicians choose to practice. The other study found that by 1979, 80 percent of rural residents were within 20 miles of physicians in internal medicine, general surgery, OBGYN, and pediatrics, and fewer than 5 percent were more than 50 miles from such specialists. Nearly 60 percent were within 20 miles of a physician in one of the major surgical subspecialties.

As I noted in my confirmation hearing, lower Medicare payments for physician services in rural areas rather than urban areas may contribute to the relative shortage of physicians in some rural areas. We will examine this in our review of issues in rural health.

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Senator Packwood Question 6

QUESTION: The quality and accessibility of health care is critical to rural communities thoughout the United States. In 1984, with the enactment of the Tax Equity and Fiscal Responsibility Act (TEFRA), limitations were placed on increased allowable costs for hospital care. However, the TEFRA regulations which deal with exceptions to allowable cost limitations related to an expansion or discontinuance of service are burdensome and expensive for rural hospitals to pursue. For example, a rural hospital in Madras, Oregon exceeded its cost limitation when it opened a new intensive care unit. As a result, this hospital lost $20,500 in reimbursement. Before the regional office will adjust the limits for the opening of the ICU, the hospital must provide HCFA with a special magnetic tape containing records for each of its Medicare discharges for a full year. This is an expensive task for a small hospital. What modifications to the TEFRA regulations, which deal with exceptions to allowable cost limitations related to an expansion on discontinuance of service, can the Department suggest to make the process less onerous for rural hospitals?

ANSWER: I can understand your concern for rural hospitals and the expense and effort that may be required of them in pursuing an exception to the TEFRA limits. However, I am informed that situations such as these may be resolved in a simpler and less costly manner. This involves a written analysis of the costs that were incurred based on the introduction of a new service. This method does not involve a listing of beneficiaries or submission of discharge data on magnetic tape.

I have mentioned your concerns to staff of HCFA and they will work with your staff to assure that this matter is investigated.

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Senator Bentsen Question 1

QUESTION: Many of us on the Finance Committee have an interest in encouraging the use of ambulatory surgical centers where appropriate for Medicare reimbursed procedures. I am advised that the original ASC procedures list was published almost 4 years ago, and has not yet been revised, despite an extensive cooperative effort between HCFA and the medical community to update the list. Why has there been a delay in the publication of the new list of procedures? When might we expect to see a final published version of the revised list?

ANSWER: A Notice of Proposed Rulemaking was published in the Federal Register on February 16, 1984, to revise the original 1982 list. I understand that HCFA sent comments received during the comment period to the appropriate professional organizations for their input. This input was then taken into account in preparing the Final Notice. The number of procedures recommended for inclusion was substantial. HCFA staff has advised me that virtually every CPT-4 code in the surgery section of the manual was commented upon at least once.

HCFA staff have also informed me that the Final Notice had been prepared in draft, but then HCFA identified data indicating that a number of procedures might not belong on the list. The data indicated that the procedures in question were being performed more often in doctors' offices than in other settings. One statutory criterion for a procedure to be on that list is that it must not be one which is commonly performed in a doctor's office.

Therefore, the list has been subjected to further staff review, so that necessary corrections and deletions may be made, before final agency and Department approval and publication in the Federal Register. As Administrator, I would seek to promptly resolve any outstanding issues and proceed expeditiously to publish the Final Notice.

Senator Bentsen Question 1a

QUESTION: What is your view of the ASC complaint regarding reimbursement rates? And will the Administration seek changes in payment levels for outpatient care in either hospital based settings or ASCs.

ANSWER: HCFA has developed a survey instrument to gather data on current ASC costs and charges. I understand that it currently is scheduled to be sent to participating ASCs during May for completion and return by July 1986. These data will be used to evaluate Medicare's current ASC payment rates. Changes in the rates will be made if appropriate.

Current law requires that payment for services furnished in a hospital outpatient department be based on reasonable costs. The law does give the Secretary authority to impose limits on reasonable costs; however, these limits have historically applied to very broad categories of institutional cost (i.e. hospital routine services). In order to establish limits on outpatient rates for specific procedures, a major change in coding and accounting systems would be required.

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Senator Bentsen Question 2

QUESTION: Dr. Roper, in the Deficit Reduction Act of 1984, Section 2132, HCFA was requested to study methods of reimbursing Certified Registered Nurse Anesthetists (CRNAs). Since the current temporary legislation on CRNA payment is set to expire on October 1, 1987, would you give us a status report on the CRNA study? And would you share with us your understanding of the recommendations you expect HCFA to make on this important issue?

ANSWER: On September 30, 1985, the Center for Health Economics Research (CHER) was awarded a cooperative agreement to collect and analyze data on the activities and employment settings of certified registered nurse anesthetists (CRNAs). To date, CHER has been designing research models for the study. Pilot tests of survey forms have been conducted at two hospitals. On May 15, 1986, the research models and the results of the pilot surveys will be discussed with a Technical Advisory Panel. It will be comprised of two anesthesiologists, two CRNAs, one nurse administrator, and one biomedical engineer engaged in anesthesia research.

The study will be completed in the fall with a final report due from CHER in early 1987. The results of this study will assist HCFA in the preparation of the Report to Congress, required under Section 2312(d) of the Deficit Reduction Act of 1984, on possible methods of Medicare reimbursement which would not discourage the use of CRNAs by hospitals. HCFA's recommendations, to be included in the Report, will be dependent upon the results of CHER's study.

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Senator Baucus Question 1

QUESTION: The report on Medigap insurance is now several years overdue and it is now almost a year since the Department stated that the completed report was in clearance. When will Congress receive this report and what issues remain to be resolved before the Secretry's recommendations will be transmitted?

ANSWER: A draft of the Medigap report mandated by section 1882 of the Social Security Act was prepared last year and was under review in the Department when former Secretary Heckler testified last May. This report deals with several very technical issues and, because so much time has elapsed since it was last drafted, we are presently updating the information it contains about State approaches to regulation of Medicare supplemental health insurance policies, coverage descriptions and the kinds of problems which consumers have recently experienced.

This update should be completed soon and I expect the report will be transmitted to Congress as quickly as possible. Secretary Bowen and I are committed to providing prompt responses to congressional inquiries. I intend to make completion of this Medigap report a high priority.

Senator Baucus Question 2

QUESTION: I understand that the Department plans to republish the Guide which is provided to Medicare beneficiaries which contains advice for those considering purchasing private supplemental health insurance. When will this Guide be completed? What revisions to the current publication are being considered? What outside groups will be asked to review the revised Guide while it is still in draft from prior to final publication?

ANSWER: The 1986 edition of the Guide to Health Insurance for People With Medicare is in production, with an expected publication date of May 16. Revisions in the '86 edition include changes to reflect the current Medicare Hospital Insurance (Part A) deductible and the Medical Insurance (Part B) deductible and coinsurance amounts. An additional revision clarifies the language concerning beneficiary liability for blood coverage under Part B.

The Guide was originally developed in cooperation with the National Association of Insurance Commissioners who generally review the HCFA draft prior to publication. Last August, we invited 26 beneficiary organizations to participate in a meeting to discuss revisions on all of our beneficiary publications including the Guide. All though not all 26 groups attended the meeting, we did meet with the AARP, the Gray Panthers, the National Council on Senior Citizens, the National Association of Area Agencies on Aging and organizations representing the Hispanic community. Before we print the 1987 edition of the Guide, we anticipate soliciting detailed comments on the publication from the same 26 organizations plus additional beneficiary groups expressing interest in the Guide, in an effort to make the Guide more effective. I would be glad to have your input on additional groups we should consult.

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Senator Baucus Question 3

QUESTION: During your nomination hearing, you stated that you believe that the sharp increase in the Medicare Part A deductible, the amount paid by beneficiaries for the first 60 days of hospital coverage, has been unfair to many elderly. Do you also believe that the Administration should submit legislation to Congress to address this problem? When will I receive a reply to my letter to Secretary Bowen of April 9 requesting the Department's views on this subject?

ANSWER: Secretary Bowen has asked the Health Care Financing Administration to evaluate alternative options for making annual adjustments to the inpatient hospital deductible and related coinsurances. In carrying out this assignment, HCFA will examine the various impacts on beneficiaries as well as the costs to the Hospital Insurance Trust Fund. When this review is concluded, senior officials within the Department will discuss it before recommending a course of action.

I anticipate the Secretary will reply to your April 9 letter shortly. Secretary Bowen and I are aware of your keen interest in this area. You may be certain that I will give it a high priority.

Senator Baucus Question 4

QUESTION: How many Medicare beneficiaries have no or only partial supplemental coverage for increases in the Medicare deductible? How much of the cost increase in the Medicare deductible is passed along in the form of higher premiums?

ANSWER: Although your 1979 Amendment does not require coverage of the Part A deductible by Medicare supplement policies, many Medicare supplement policies do cover this Part A deductible. Of the Blue Cross and Blue Shield plans, which cover about 40 percent of Medicare beneficiaries, 84 out of 90 plans provided this benefit in 1982.

Estimates from the 1982 SRI survey conducted for HCFA (the latest data available) indicate that over 90 percent of the supplemental policies provide this benefit. These estimates are based on survey results from six States, and may not apply nationwide. All States have adopted legislation or regulations which require that coverage of benefits designed to cover cost sharing amounts under Medicare be changed automatically to coincide with changes in the applicable Medicare deductible amount and co-payment percentage factors.

While all States require the coverage of Medicare co-payment percentages, not all States require coverage of the Medicare deductible. As a part of our current analysis of these issues, we are seeking answers to questions about the relationship between changes in the Medicare hospital deductible and Medigap policy premiums.

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Senator Heinz Question 1

QUESTION: Investigations by the Special Committee on Aging, which I chair, have revealed that Peer Review Organizations are limited to a "snap shot" of the health care delivery system by only reviewing hospital stays. Will HCFA consider expanding the PRO scope of work to include quality review of nursing homes, doctors' offices, home health agencies, and health maintenance organizations?

ANSWER: PROs have been in existence less than 2 years. We are currently evaluating their performance under the first cycle of contracts. We have found that some PROs did not meet their contract objectives and our expectations of performance in the first 2 years.

Since quality of care in the inpatient setting is a matter of utmost importance under PPS, we have strengthened the PRO Scope of Work for 1986. We believe this is a substantial challenge. Until we are convinced that PROs can perform satisfactorily to assure quality of care in the inpatient setting, we believe it would be inappropriate to expand their responsibilities.

The TEFRA Health Maintenance Organizations/Competitive Medical Plans (HMO/CMPs) are required to have an internal quality assurance program and to have a grievance procedure that is outlined for beneficiaries at the time they enroll. Further, HCFA is reviewing data on why beneficiaries have disenrolled from HMO/CMPs to identify potential problems with quality of care in individual plans. In addition, the Administration is encouraging the industry to develop mechanisms to monitor quality of care without government intrusion. In this regard, although the recently enacted Consolidated Omnibus Budget Reconciliation Act of 1985 would require PROs to begin review of HMO/CMPs on January 1, 1987, the conference committee stated that the delayed effective date would allow the industry time to develop their own system for quality review. The delayed data will allow review of the industry approach before implementing PRO review.

Senator Heinz Question 2

QUESTION: The Congress and Administration share a concern for the quality of health care under the new Medicare prospective payment system. Under DRGs, patients are being discharged both quicker and sicker, often requiring high levels of post hospital care. At the same time, HCFA appears to be tightening up on reimbursements for post-hospital care (home health and nursing home). Will you commit to a reassessment of HCFA coverage policy for skilled nursing and home health benefits to meet this increased need for post-hospital care?

ANSWER: I am also concerned that the operation of PPS provide the highest possible quality of care for Medicare beneficiaries. The Health Care Financing Administration is currently reviewing issues related to the extent to which current experience under PPS and Medicare is consistent with post hospital needs of the elderly.

This is obviously an issue of major importance. I pledge continued cooperation and exchange of ideas between the Congress and the Administration on this matter.

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Senator Heinz Question 3

QUESTION: What is HCFA doing to ensure that beneficiaries get appropriate information when they need it — and moreover — that they understand their rights and how to exercise them?

ANSWER: A major accomplishment of HCFA this year has been publication of "An Important Message from Medicare". Clearly, we want to make sure that hospitals are appropriately disseminating the message about beneficiary discharge and appeal rights. Hospitals are required to provide the Message from Medicare upon admission to the hospital. We have issued instructions to the PROs detailing their responsibilities for monitoring the dissemination. The PROs were to begin monitoring on March 24.

HCFA wants to ensure that beneficiaries and their families and friends are aware that they should receive a copy of the information upon admission to the hospital. Secretary Bowen issued a press release regarding the message to beneficiaries on February 24, which received extensive media coverage. Additionally, just a few days ago, HCFA issued the April Medicare/Medicaid Notes devoted to the issue. Medicare/Medicaid Notes has an increasingly wide circulation throughout the beneficiary community. HCFA sends it to the national beneficiary organizations for use especially in their newsletters, to some State and local groups, through the Administration on Aging to all the Area Agencies on Aging and through the Social Security Administration to their local offices.

HCFA appreciated the Aging Notes of April 9, issued by the Senate Special Committee on Aging, that was devoted to the message to beneficiaries.

HCFA is discussing patient appeal rights in all meetings with beneficiary groups — particularly the availability and content of the message to beneficiaries. After there has been adequate "real world" experience, I would anticipate an assessment of how, if possible, we could make the message even more effective.

HCFA has updated and expanded the Medicare Handbook regarding appeal rights, and is now drafting a new pamphlet which will give comprehensive information regarding the appeals process, along with another new pamphlet informing beneficiaries and their families as to what they should know about the PPS, particularly with regard to their in-hospital stays under PPS.

HCFA has met with several national consumer group representatives in seeking additional ways to make our beneficiary education initiatives as effective as possible. This will be a continuing priority for HCFA in the future.

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Senator Heinz Question 4

QUESTION: I understand that the Administration intends to move full steam ahead toward a fully capitated Medicare program. What plans are in the works to ensure quality of care in a fully capitated sytem?

ANSWER: You are correct that we plan to move expeditiously to a fully capitated Medicare program. We believe that, in such a program, the market place will work to assure quality of care: those plans which do not provide adequate quality will lose subscribers and eventually cease to be financially able to participate in the system. We believe that in such a program the dominant quality assurance mechanism should be the marketplace. Of course, we do understand that Medicare has a responsibility to ensure that beneficiaries receive high quality medical care.

As I indicated in my response to your first question, we will respond to the COBRA mandate to develop a quality assurance mechanism for HMO/CMPs.

Senator Heinz Question 5

QUESTION: The President has asked Secretary Bowen to construct a proposal for catastrophic health care coverage for all Americans. What steps are being taken by the Department to examine ways to provide coverage for long-term and chronic care as part of its study?

ANSWER: Secretary Bowen plans to examine all available information, to consider every proposal, and to consult widely with Federal officials, members of the Congress, medical and consumer groups, and other representatives of the private sector, before developing a final report to the President.

In order to do this, the Secretary has set up three separate workgroups: long term care for the aged, catastrophic care for Medicare-aged, and catastrophic care for the non-Medicare population. These three groups will report their findings to a Department-wide Executive Committee.

In addition, an outside Private/Public Sector Advisory Committee, composed of consumers, providers and others interested in catastrophic-long term care, has been created to provide additional advice on this important subject. This group will have its first meeting on April 30, here in Washington.

Secretary Bowen plans to deliver his report to the President by the end of the year.

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Senator Heinz Question 6

QUESTION: I am pleased with HCFA's recent decision to provide the Peer Review Organizations with the computer technology needed to police DRG gaming by hospitals. When can we expect to find these computers in place and operating?

ANSWER: The GROUPER edit systems currently available to PROs are helpful in profiling changes required as the result of DRG validation. The requirement to utilize this technology is being included in the contracts with PROs as they are renewed. The new contracts call for the first computers to be installed in July 1986, with all PROs having computers by November 1986.

In addition, we are very concerned that DRG coding validation be accurately performed by PROs. In that regard, we are including (in the 1986-1988 Scope of Work) that DRG validation be supervised by an Accredited Records Technician or a Registered Records Administrator.

Senator Heinz Question 7

QUESTION: Out of fear of retrospective payment denials, home health and skilled nursing facilities in my home State of Pennsylvania, and other States, have stopped accepting referrals for rehabilitation services such as physical and occupational therapy. Could you comment on how you think HCFA could and should address these concerns by the providers, so that beneficiaries will continue to receive the post-hospital care they need?

ANSWER: We have plans to initiate a pilot test for prior authorization of proposed admissions to skilled nursing facilities and to home health care. This initiative will enable us to evaluate the medical needs of Medicare patients before admission to a SNF or to home care, thus reducing the number of retroactive denials that are of concern to such providers.

Senator Heinz Question 8

QUESTION: Facilities reimbursed under the comprehensive outpatient rehabilitation facility (CORF) Medicare provision are experiencing extreme problems having their claims paid or even reviewed for payment by the fiscal intermediaries. What measures will HCFA take to see that CORF claims are processed within 30 days of submission?

ANSWER: CORFs are a relatively new provider type. As a result, HCFA has subjected them to 100% medical review. Further, because CORFs are currently so few in number, automated claims payments screens are not commonly available thus necessitating normal processing. These factors have resulted in some claim payment delays.

If confirmed, I will make it a priority to reassess the 100% medical review requirement for CORFs.

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Senator Symms Question 1

QUESTION: The Federal Trade Commission issued a report which said that generic prescription drugs saved consumers some $236 million in 1984. What, if anything, is HCFA doing to encourage retail pharmacies to dispense generic drugs to needy Medicaid recipients?

ANSWER: The Department is committed to changing current regulations in order to take advantage of the savings achievable through dispensing of generic drugs. Staff have developed three alternative approaches, each of which would encourage retail pharmacies to dispense generic drugs to Medicaid recipients.

Under the Pharmacists' Incentive Program (PhIP), States could reimburse pharmacies a percentage (e.g., 150 percent) of the least costly generic drug. The pharmacy could retain the difference between what it pays for the drug product and the PhIP limit, in addition to the dispensing fee it receives.

Under the Competitive Incentive Program (CIP) drugs would be reimbursed at a discount from retail prices. The discount would be greater for name brand drugs than for generic drugs, thus providing an incentive for generic substitutions.

Under a revision of the present Maximum Allowable Cost (MAC) Program, the process for establishing MAC limits — that is the maximum amounts recognized as the cost of selected drugs —would be streamlined. In addition the pricing of drugs for purposes of setting the MAC limits would be revised to recognize wholesale prices (since many pharmacies purchase from wholesalers rather than directly from manufacturers). Pharmacies could receive the MAC limit amount plus a dispensing fee.

A Notice of Proposed Rulemaking is scheduled to be published this Spring, and a Final Rule is expected to be issued this Fall.

Senator Symms Question 2

QUESTION: Estimates indicate that as much as 50 percent of Medicaid paperwork consists of processing and auditing prescription drug claims but that these drug claims represent less than 10 percent of total expenditures for the program. This must be an expensive administrative process. Can we save money here by streamlining regulations to minimize this paperwork problems?

ANSWER: This administration is committed to reducing unnecessary paperwork whenever and wherever possible. As discussed in response to your first question, the Department is currently considering several options for reforming Medicaid drug reimbursement. Even though States have considerable lattitude in implementation of drug payment systems, I can assure you that whichever system is ultimately adopted, it will reflect our concerns for reduced administrative burden.

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Senator Symms Question 3

QUESTION: Has HCFA given any consideration to developing a voucher system for drugs which could be fashioned with the latest technology such as using computers and the new smart cards? I have heard that smart cards or benefit cards are capable of virtually eliminating all waste, fraud and abuse and that many Federal agencies including Agriculture Department and Social Security are looking at this concept. What is HCFA doing?

ANSWER: The "SMART" card idea is in its early stages of development for Medicaid programs. The State of New York is beginning a pilot program to use a "SMART" card for eligibility determinations for all recipients. This type of card is also under consideration by other States. We are not aware of the card being used as a voucher for payment by any State.

However, we understand that the American Pharmaceutical Association is interested in linking a voucher approach with the use of a "SMART" identification card. Under this approach the card would be given to a pharmacist when a prescription is to be filled. The card would allow for an eligibility check with the State agency before a prescription is filled. The pharmacist would then be able to use the receipt of the eligibility confirmation as a voucher to submit to an approved bank for payment.

I would be extremely interested in any approaches to reimbursement which would eliminate or reduce fraud and abuse. I would be pleased to receive more information from you on this issue.

Senator Symms Questions 4-8

QUESTIONS: Why do Medicare patients in Idaho continue to receive letters stating that there is incomplete documentation of the necessity of the pathologists services? Do you believe this service is unnecessary? And is it appropriate for those of us in Washington to override the medical needs of an entire qualified medical staff by saying that the consultations are unnecessary? Why would the rulings and/or interpretation of the regulations regarding the interpretation of cardiac profiles vary from one region to another? Could you please clarify these criteria? Finally, could you clarify the appeals process in Region X?

ANSWER: Regulations describe the kinds of services which can be reimbursed under Part A and which can be reimbursed under Part B. In order to be reimbursed under Part B, certain criteria must be met. In general, these are the criteria which you have listed in Question 4. I am not now familiar with the situation you noted at West Valley Medical Center in Idaho. If confirmed, I will immediately investigate the situation thoroughly, with a view toward expeditious resolution. In that regard I would be pleased to meet with you at your early convenience to discuss this situation.

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Senator DURENBERGER. Oh, yes.

Dr. ROPER. I pledge to work with you, Senator.

Senator BRADLEY. OK. So we will talk about that, because I think it is——

Dr. ROPER. If I could just make a short comment. The thing you cite is only one of a thousand examples of the frustration of managing a program such as Medicare from Washington; it is one of the strongest arguments I know of for capitation which devolves those kind of decisions to the local level. We don't need to be making decisions in Washington over whether somebody needs home care or not.

Senator DURENBERGER. Dr. Roper, we are going to vacate the room so that we can have a little contest here between congressional legislative prerogatives and international relations and so forth. We have that similar problem in health policy. As chairman of the subcommittee, let me say it has been a matter of great frustration, as I think you well know, over the last several years to watch the interference of the Office of Management and Budget in matters of health and environment health policy. I see it from both sides and it is equally as bad.

Time and again the Congress has instructed the Secretary of HHS and the Administrator of HCFA to carry out policies which are essential for the implementation of our health care reform policy and which we generally agree. Time and time again the product of the Department's policy process has been perverted in a savings device or prevented from appearing in any form whatsoever.

Why is this happening? Because regardless of the Secretary's or the Administrator's interest in complying with congressional instructions, doing their job, the Office of Management and Budget, which has a very different mission, has taken upon itself to dictate policy.

Senator Baucus raised the issue of capital reform. Congress has instructed the Secretary in the Social Security Amendments of 1983 to report to Congress by October of 1984 with recommendations for capital reimbursement in the hospital DRG's. In the fall of 1985 that report was finished, but it never saw the light of day because OMB was not satisfied with the savings it produced.

Just a few weeks ago we finally received HCFA's report, unfortunately without HCFA's recommendations. Instead, what OMB allowed to be released was HCFA's test with OMB's recommendations.

HCFA's proposed demonstrations for social HMO's are a matter of history. Now I understand that similar interference from OMB is keeping the new ambulatory surgery regulations buried. HCFA has completed a lengthy review of surgeries which can safely be performed in ambulatory surgery centers and, therefore, should be covered under Medicare when performed in those centers. The list has not been revised since 1980 and HCFA's plans to almost quadruple the number of procedures approved for payment in ASC's would recognize that the health care market has changed since 1980 and more procedures are being done outside the hospital, with greater convenience to the patient, lower cost sharing, and less risk of infection. Yet the Office of Management and Budget has

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bounced these regulations back to HCFA where, unless you do something about it, they may languish for months.

So here we have three examples of new policy initiatives whose development was strangled by the Office of Management and Budget in order to come up with the right numbers.

I trust that your relationships with the Congress, as well as with the administration and the Office of Management and Budget, will signal an improvement in the development of health policy, and I would also like to receive from you some assurance that you will commit yourself to notify this committee whenever the Office of Management and Budget causes HCFA to miss a statutory or court-ordered deadline.

Dr. ROPER. Senator, I am aware of the history that you speak about. It is a new day, and what I would like to do is talk about the future. There is a new team in OMB and a new one soon to be at HHS, and I think we are going to be able to work together well.

My desire is to serve the President and the Secretary so that we come up with policy that makes sense and convince other people, whether on OMB or on Capitol Hill, that it makes good sense.

Senator DURENBERGER. Are there any other questions or comments from any members of the subcommittee?

[No response.]

Senator DURENBERGER. If not, we thank you, Dr. Roper, and we thank your family for being here.

The hearing is adjourned. We will all leave the room by the back door as quickly as possible so all the trade folks can take us over.

[Whereupon, at 9:20 a.m., the hearing was adjourned.]

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